X. Record Management

A. Local Policy and Standing Orders

Each health department must have local policies and standing orders approved, signed, and annually updated by the health director, PHN administrator, TB nurse, and the local TB physician/medical consultant.

B. Clinical Records

1. Each health department must have a clinical record system that provides medical and legal documentation of services rendered including a recall system for required follow-up.

2. Records must be clear, concise, and descriptive of the course of care for the patient. Documentation should include counseling, services rendered that are not documented elsewhere, services rendered on behalf of the patient, and follow-up attempted and/or completed.

3. Agency policy must define the types and location of various components of the complete record system.

4. The following forms may be downloaded from the TB Control website http://epi.publichealth.nc.gov/cd/tb/lhds.html#forms to be utilized as the department deems appropriate in their overall patient record system:

   a. Tuberculosis Register Card (DHHS 2245)
      - May be used if health department finds it useful.
      - Provides an overview of patient status and services rendered.
      - Serves as a "tickler" or recall system for required follow-up.
      - Initiated on persons currently receiving services and placed in the register.
      - Filed in the clinical record upon termination of services or placed in a separate section of the register pending nurse consultant review.

   b. Tuberculosis Drug Record (DHHS 1391)
      - Serves as a medical, legal record of drugs supplied.
      - Provides uniform record for all patients receiving TB drugs.
      - Initiated on all persons started on drugs and placed in the chart or a loose-leaf notebook in alphabetical order.
      - Reviewed at least weekly to recall patients due for refills.
      - Filed in the clinical record upon termination of drug therapy.

   c. Tuberculosis Flow Sheet (DHHS 2810)
      - Provides documentation of monitoring for adverse drug reactions **prior to providing refills.**
      - Placed in the clinical record upon termination of drug therapy.

   d. Tuberculosis Epidemiological Record (DHHS 1030)
      - Provides TB-related medical and epidemiological history.
      - Provides documentation of chest x-ray reading and medical orders.

- Provides documentation of patient education and consent/refusal for services.

e. Record of TB Contacts (DHHS 1662)
- Provides a summary of contacts identified and evaluated.
- Initiated for each TB suspect/case that has contacts identified.
- Placed in TB suspect/case clinical record upon completion of contact investigation.

f. Record of Tuberculosis Screening (DHHS 3405)
- Provides a record of the individual's tuberculosis status.
- Provides a record of annual verbal screening for employment/residency requirements.

C. Obtaining Records from Other Providers

G. S. 130A-144 (b) requires physicians and persons in charge of medical facilities or clinical or pathology laboratories to permit the State Health Director and local health directors to obtain a copy of medical records pertaining to communicable diseases or conditions.

A written release signed by the patient is advised in all situations where possible, but is **not** legally required within North Carolina.

1. Substance Abuse Facilities:

   a. Provide written release signed by the patient; or
   b. Initiate a signed agreement between the substance abuse facility and the local health department for sharing of communicable disease patient information.

2. VA Hospitals require VA 10-5345 for records release.

3. N.C. Department of Corrections:

   a. Request records/status reports of current inmates from the nurse at the inmate's prison unit.
   b. Request records of released inmates from:

      Medical Records Manager, DOP Health Services
      2405 Alwin Ct, Raleigh, N.C. 27699-4268
      Telephone: (919) 715-1570 or 919-715-1584
      Fax: 919-715-1581

4. Sanitoria Records:

   Patient records and x-rays from N.C. sanatoria are no longer available.

D. Transferring Records

1. No release is required to transfer records between health departments in North Carolina.

2. Interstate Transfer of Records:

   a. Obtain a signed release from the patient if possible (**not required** for transferring information necessary for patient follow-up).
   b. Call TB nurse in receiving jurisdiction.
   c. Prepare a summary (TST, x-ray, drug record, HIV status, M. tuberculosis cultures and susceptibilities).
   d. Forward information to receiving jurisdiction; the Interjurisdictional TB Notification Form can be found in this chapter or can be downloaded from the NTCA web site at http://www.tbcontrollers.org/resources/interjurisdictional-transfers/#.V46YCqKUJ-8

E. Record Retention

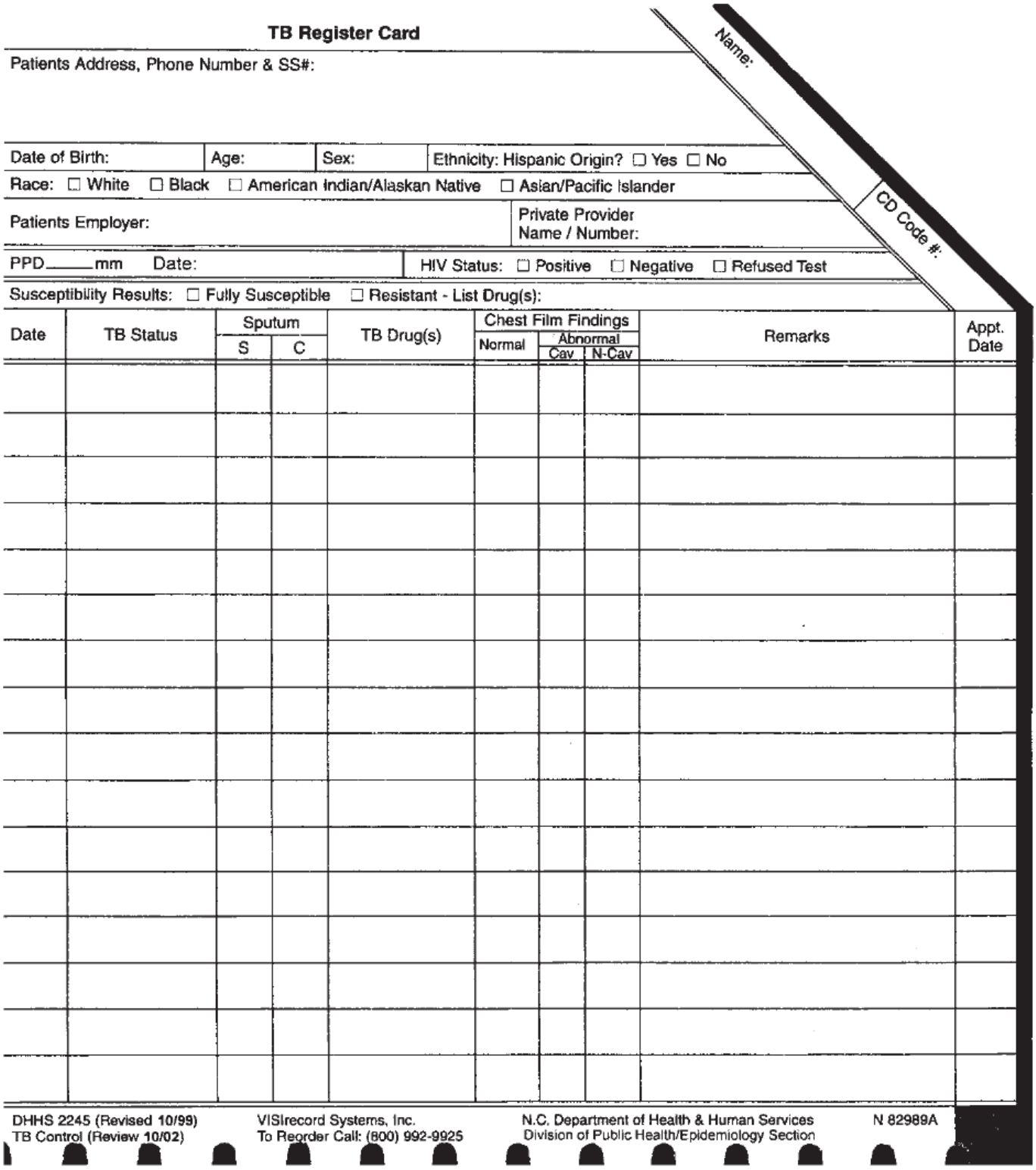
The following is paraphrased from the Records Retention and Disposition Schedule, Local Health Departments, September 7, 2007, page 89, item 10, including recent amendments, published by the Division of Archives and History: http://archives.ncdcr.gov/Portals/3/PDF/schedules/Amendments/Local_Health_Departments_Amendment_20091030.pdf?ver=2016-04-29-124923-250

1. TB infection; no TB disease (TST positive; chest x-ray negative for TB)
   a. **Retain** for the life of the individual:
      - Last x-ray interpretation;
      - TB Drug Record, if treated; and
      - HIV test results, if tested.
   b. **Destroy** x-ray films 10 years after the last date of any health department services.

2. TB disease (treated as a clinical or laboratory confirmed TB case):
   a. **Retain** for the life of the individual:
      - Last **x-ray film and** interpretation;
      - TB Drug Record(s);
      - Last M. tuberculosis culture result with susceptibilities;
      - HIV test results, if tested;
      - Summary of treatment; and
      - Hospital discharge summaries, if any.
   b. **Destroy** all but the most recent x-ray film after 10 years.

3. **Destroy** all records and x-ray films
   a. Upon death **if** more than 10 years after the last date of any health department services; or
   b. When patient reaches 90 years of age **if** more than 10 years after the last date of any health department services.

F. Tuberculosis Register Card (DHHS 2245)



TB Register Card

Name:

CD Code #:

Patients Address, Phone Number & SS#:

Date of Birth: | Age: | Sex: | Ethnicity: Hispanic Origin? ☐ Yes ☐ No

Race: ☐ White ☐ Black ☐ American Indian/Alaskan Native ☐ Asian/Pacific Islander

Patients Employer: | Private Provider Name / Number:

PPD____mm Date: | HIV Status: ☐ Positive ☐ Negative ☐ Refused Test

Susceptibility Results: ☐ Fully Susceptible ☐ Resistant - List Drug(s):

Date	TB Status	Sputum		TB Drug(s)	Chest Film Findings			Remarks	Appt. Date
		S	C		Normal	Abnormal Cav	Abnormal N-Cav		

DHHS 2245 (Revised 10/99) TB Control (Review 10/02) | VISIrecord Systems, Inc. To Reorder Call: (800) 992-9925 | N.C. Department of Health & Human Services Division of Public Health/Epidemiology Section | N 82989A

Remarks:

Contact Surveillance

Name(s), Address & Phone Number, if not same as case	Birth Date / Age	Exposure	Date Mantoux Test/ mm Result	Date Chest Film	Date INH Begun	Remarks	Appt. Date
		Close ☐					
		Casual ☐					
		Close ☐					
		Casual ☐					
		Close ☐					
		Casual ☐					
		Close ☐					
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		Casual ☐					
		Close ☐					
		Casual ☐					

DHHS 2245 (Revised 10/99)
TB Control (Review 10/02)

N 82969B

G. Tuberculosis Drug Record (DHHS 1391)

H. Tuberculosis Flow Sheet (DHHS 2810)

I. Tuberculosis Epidemiological Record DHHS 1030)

J. Nursing Record of Tuberculosis Contacts (DHHS 1662)

K. Record of Tuberculosis Screening (DHHS 3405)

L. Veterans Administration Records Release Form

OMB Number: 2900-0260
Estimated Burden: 2 minutes

Department of Veterans Affairs

REQUEST FOR AND AUTHORIZATION TO RELEASE MEDICAL RECORDS OR HEALTH INFORMATION

Privacy Act and Paperwork Reduction Act Information: The execution of this form does not authorize the release of information other than that specifically described below. The information requested on this form is solicited under Title 38, U.S.C. The form authorizes release of information in accordance with the Health Insurance Portability and Accountability Act, 45 CFR Parts 160 and 164, 5 U.S.C. 552a, and 38 U.S.C. 5701 and 7332 that you specify. Your disclosure of the information requested on this form is voluntary. However, if the information including Social Security Number (SSN) (the SSN will be used to locate records for release) is not furnished completely and accurately, Department of Veterans Affairs will be unable to comply with the request. The Veterans Health Administration may not condition treatment, payment, enrollment or eligibility on signing the authorization. VA may disclose the information that you put on the form as permitted by law. VA may make a "routine use" disclosure of the information as outlined in the Privacy Act systems of records notices identified as 24VA19 "Patient Medical Record - VA" and in accordance with the VHA Notice of Privacy Practices. You do not have to provide the information to VA, but if you don't, VA will be unable to process your request and serve your medical needs. Failure to furnish the information will not have any affect on any other benefits to which you may be entitled. If you provide VA your Social Security Number, VA will use it to administer your VA benefits. VA may also use this information to identify veterans and persons claiming or receiving VA benefits and their records, and for other purposes authorized or required by law. The Paperwork Reduction Act of 1995 requires us to notify you that this information collection is in accordance with the clearance requirements of section 3507 of the Paperwork Reduction Act of 1995. We may not conduct or sponsor, and you are not required to respond to, a collection of information unless it displays a valid OMB number. We anticipate that the time expended by all individuals who must complete this form will average 2 minutes. This includes the time it will take to read instructions, gather the necessary facts and fill out the form.

ENTER BELOW THE PATIENT'S NAME AND SOCIAL SECURITY NUMBER IF THE PATIENT DATA CARD IMPRINT IS NOT USED.

TO: DEPARTMENT OF VETERANS AFFAIRS (Print or type name and address of health care facility)	PATIENT NAME (Last, First, Middle Initial) SOCIAL SECURITY NUMBER

NAME AND ADDRESS OF ORGANIZATION, INDIVIDUAL OR TITLE OF INDIVIDUAL TO WHOM INFORMATION IS TO BE RELEASED

VETERAN'S REQUEST: I request and authorize Department of Veterans Affairs to release the information specified below to the organization, or individual named on this request. I understand that the information to be released includes information regarding the following condition(s):

☐ DRUG ABUSE ☐ ALCOHOLISM OR ALCOHOL ABUSE ☐ TESTING FOR OR INFECTION WITH HUMAN IMMUNODEFICIENCY VIRUS (HIV) ☐ SICKLE CELL ANEMIA

INFORMATION REQUESTED (Check applicable box(es) and state the extent or nature of the information to be disclosed, giving the dates or approximate dates covered by each)

☐ COPY OF HOSPITAL SUMMARY ☐ COPY OF OUTPATIENT TREATMENT NOTE(S) ☐ OTHER (Specify)

PURPOSE(S) OR NEED FOR WHICH THE INFORMATION IS TO BE USED BY INDIVIDUAL TO WHOM INFORMATION IS TO BE RELEASED

NOTE: ADDITIONAL ITEMS OF INFORMATION DESIRED MAY BE LISTED ON THE BACK OF THIS FORM

AUTHORIZATION: I certify that this request has been made freely, voluntarily and without coercion and that the information given above is accurate and complete to the best of my knowledge. I understand that I will receive a copy of this form after I sign it. I may revoke this authorization, in writing, at any time except to the extent that action has already been taken to comply with it. Written revocation is effective upon receipt by the Release of Information Unit at the facility housing the records. Redisclosure of my medical records by those receiving the above authorized information may be accomplished without my further written authorization and may no longer be protected. Without my express revocation, the authorization will automatically expire: (1) upon satisfaction of the need for disclosure; (2) on _____ (date supplied by patient); (3) under the following condition(s):

I understand that the VA health care practitioner's opinions and statements are not official VA decisions regarding whether I will receive other VA benefits or, if I receive VA benefits, their amount. They may, however, be considered with other evidence when these decisions are made at a VA Regional Office that specializes in benefit decisions.

DATE	SIGNATURE OF PATIENT OR PERSON AUTHORIZED TO SIGN FOR PATIENT (Attach authority to sign, e.g., POA)

FOR VA USE ONLY

IMPRINT PATIENT DATA CARD (or enter Name, Address, Social Security Number)	TYPE AND EXTENT OF MATERIAL RELEASED	
	DATE RELEASED	RELEASED BY

VA FORM MAY 2005 **10-5345** USE EXISTING STOCK OF VA FORM 10-5345, DATED NOV 2004.

M. Interjurisdictional TB Notification Form Instructions

Interjurisdictional Tuberculosis (TB) Notification -
National Tuberculosis Controllers Association Recommendations

I. Purpose:

The movement of TB patients from one jurisdiction to another is a unique challenge to public health providers and requires that health departments share information promptly in order to maximize the likelihood of continuity of care. To understand the scope and causes of lack of continuity, it is also incumbent on health departments to take responsibility for analyzing outcomes of TB patients that move. The Interjurisdictional TB Notification system will facilitate and standardize interstate communication to enhance continuity and completeness of care. It should also improve outcome evaluation of verified cases. These forms should replace other interstate notification forms currently in use. States may choose to use other forms for internal (intrastate) notification.

In most instances, TB notifications will be exchanged between state health departments. However, in some states these notifications may be best sent directly to local jurisdictions. For guidance on how to proceed with individual states, contact the state level Interjurisdictional Contact as indicated in the NTCA directory.

II. Definitions:

A. Referring jurisdiction: The jurisdiction that initiates the interjurisdictional notification. For most Class 3 and Class 5 referrals, the referring jurisdiction will be the same as the reporting jurisdiction.

B. Reporting jurisdiction: The jurisdiction that reports a Class 3 patient to the Centers for Disease Control and Prevention (CDC) and, therefore, counts the case in their jurisdiction.

C. Receiving jurisdiction: The jurisdiction that receives the interjurisdictional notification.

D. Class 2: Latent TB infection, no evidence of current disease

E. Class 3: Verified active TB disease; in the US these would be cases that meet the CDC verification definition.

F. Class 5: A suspected case of active TB disease.

G. RVCT: The Report of Verified Case of TB is the national form used to report verified cases to the CDC.

H. F/U 2: The Follow-up 2 is the national form used to report outcomes of verified cases to the CDC.

III. Forms:

A. Interjurisdictional TB Notification: Provides a standard array of information to be transmitted to new jurisdictions for Class 3 and 5 patients, contacts, and persons with latent TB infection (LTBI), and source case findings.

B. Interjurisdictional TB Notification Follow-up: Provides a standard array of follow-up information to be transmitted back to referring jurisdictions.

IV. When to send an Interjurisdictional TB Notification:

Notifications should be sent by all jurisdictions for Class 3 and 5 cases. Notification is optional for contacts, LTBI convertors, LTBI reactors, and source case findings. In addition, notifications should not be sent for contacts, LTBI convertors, LTBI reactors, and source case findings unless reasonable locating information is available, usually consisting of at least a street address or phone number.

A. Class 3 and 5 Patients: An Interjurisdictional TB Notification should always be initiated when a Class 3 or 5 patient will be moving out of the area for 30 days or more. Notification may be initiated for patients with shorter planned stays or less than 30 days of treatment remaining at the time of their move, at the discretion of the referring jurisdiction. For example, if a patient must continue DOT after they move, a notification should be initiated.

B. Contacts: For close contacts to AFB smear positive or smear negative Class 3 pulmonary cases. If there are multiple contact to the same case, they should have individual notifications sent.

C. LTBI Convertors: For documented convertors who have initiated treatment and who will be moving out of the area for 30 days or more. The results and dates of the last negative skin test and the first positive skin test must be entered into the Contact/LTBI section to provide information on when the skin test conversion occurred.

D. LTBI Reactors: For Class 2 and 4 patients who have initiated treatment and who will be moving out of the area for 30 days or more. For Class 2 patients, include specific risk factors for disease progression to assist receiving jurisdictions prioritize follow-up.

E. Source Case Finding: For investigation of close associates to a Class 3 index case when that index case has a clinical presentation consistent with recently acquired disease (e.g. children who are ≤3 years of age). Notifications should not routinely be sent to perform source case finding for a child with LTBI.

V. Instructions for Interjurisdictional TB Notification form:

Indicate when key information is unknown or pending, do not just leave blank.

***A. Referring Jurisdiction Information*:** Complete all information to provide specific contact information for the receiving jurisdiction.

***B. Referral Category*:** Specify the type of patient referral. For verified cases, supply the RVCT number and State that reported to the CDC. This will allow the receiving jurisdiction to ensure the F/U 2 is sent to the reporting jurisdiction. Attach the RVCT form whenever possible. For classified immigrants attach pertinent overseas forms when available.

***C. Patient Information*:** Complete all information. If some elements are unknown, indicate this in the space provided. The *Emergency Contact* should be a relative or associate who is likely to have locating information about the referred patient.

D. Clinical Information: When some or all of the laboratory information is pending at the time of referral, the referring jurisdiction should indicate this and update the information when available. To ensure rapid transfer of information, updates should be accomplished by faxing an updated Notification form or by calling the receiving jurisdiction. The TST information in this section should be used for cases/suspects only. Attach copies of laboratory and X-ray information whenever possible. The *Other* section should include additional types of tests including CT scans, NAAT tests – attach copies of the reports whenever possible.

E. Contact/LTBI Information: This section should be used for contacts, convertors, and reactors. The TB skin test #1 and #2 should be completed for all convertor referrals and for other referrals when appropriate. For contact referrals, exposure information should be completed to enhance appropriate investigation by the receiving jurisdiction.

F. Medications: Complete as indicated. Supply adherence information that may be of importance to the receiving jurisdiction for appropriate patient management.

G. Follow-up: All Class 3 and 5 referrals require an Interjurisdictional TB Notification Follow-up to be sent by the receiving jurisdiction. For other referral categories, the referring area should indicate if the Follow-up form is requested. Note that the ultimate decision to provide follow-up for contacts, convertors, and reactors is at the discretion of the receiving jurisdiction.

VI. When to send the Interjurisdictional TB Notification Follow-up:

A. 30-day status: At 30 days after notification was received, a status report should be sent to the referring jurisdiction. In instances when the patient is not located within 30 days,

"lost" will be considered to represent the final disposition. If the patient is subsequently located, an update should be sent to the referring jurisdiction using the Follow-up form.

Some jurisdictions may not perform follow-up on contact, LTBI, or source case finding referrals. In these cases, the final status of "no follow-up performed" should be indicated. Follow-up should be performed and sent to referring jurisdictions for all Class 3 patients.

B. Interim status: May send if an interim update in status is appropriate.

C. Final status: When a final status is known.

VII. Instructions for Interjurisdictional TB Follow-up form:

A. Date Notification Received: Receiving jurisdiction should indicate the date the Interjurisdictional Referral was received.

B. Status:
30 days: At 30 days after notification was received, a status report should be sent to the referring jurisdiction. In instances when the patient is not located within 30 days, "lost" will be considered to represent the final disposition. If the patient is subsequently located, an update should be sent to the referring jurisdiction using the Follow-up form.

Interim: Should use whenever updated information needs to be sent to the referring jurisdiction.

Final: To be used at the time a final status is known.

C. Return follow-up form to: The receiving jurisdiction should complete this information using the contact information provided on the original Interjurisdictional Referral form (or may use the Interjurisdictional Contact information from the NTCA Directory).

***D. Patient information*:** Complete as indicated.

E. Case: Final outcome in the receiving jurisdiction will be indicated. The F/U 2 should be sent to the reporting jurisdiction. The original reporting area will be responsible for getting F/U 2 results to the CDC.

F. Suspect: The receiving jurisdiction will indicate whether the Class 5 case was verified, and if so, the method of verification. In some cases, the referring jurisdiction may still be the appropriate jurisdiction to report the case. If so, the receiving jurisdiction should also provide a final follow-up status and F/U 2 to the reporting jurisdiction (see *Case* above). This section can also be used to provide follow-up information for individuals investigated as part of a source case finding.

G. Contact: Some jurisdictions may not provide follow-up on all contact referrals and should indicate, "No follow-up performed" on the 30-day status report. If follow-up is performed, indicate the final outcome. Whenever possible, the receiving jurisdiction should attach contact follow-up information including screening dates and results, as well as treatment dates and outcome. This will assist the referring area in completing contact information required by the CDC.

***H. LTBI*:** Some jurisdictions may not provide follow-up on all LTBI referrals and should indicate, "No follow-up performed" on the 30-day status report. If follow-up is performed and the patient is located, indicate the outcome. This section can also be used to provide follow-up information for convertors.

N. Interjurisdictional TB Notification Form

Interjurisdictional Tuberculosis Notification

Referring
Jurisdiction_city _____ county _____ state _____ Date sent ____/____/____
Contact person_____ Phone ( ) _____ FAX ( )_____

☐ Verified case State reporting to CDC:_____ RVCT#_____(attach RVCT) ☐ Not reported_____
☐ Suspect case ☐ Close contact ☐ Reactor (LTBI) ☐ Convertor (LTBI) ☐ Source case investigation ☐ A/B Classified Immigrant

Patient name_____ Sex ☐M ☐F
Last First Middle

AKA_____

Date of birth ____/____/____ Interpreter needed? ☐ No ☐ Yes, specify language_____
New address _____ Hispanic ☐No ☐Yes
Number/Street/Apt. Race ☐White ☐Black ☐Asian
☐Am.Indian/Nat.Alaskan.
City/State/ZipCode ☐Other:_____

New telephone ( )_____ Date of expected arrival ____/____/____
New health provider ☐ Unknown ☐ Known (name, address, phone)_____
Emergency contact: Name_____ Phone ( )_____
Relationship_____

Clinical information for ☐ this referred case/suspect ☐ index case for this contact ☐ not applicable

Date of Collection	Specimen type	Smear	Culture	Susceptibility	Chest X-ray	Other

Site(s) of disease: ☐ Pulmonary ☐ Other(s) specify all_____
Date 1st negative smear ____/____/____ ☐Not yet Date 1st negative culture ____/____/____ ☐ Not yet
TB skin test #1:Date ____/____/____ Result ____mm TB skin test #2: Date ____/____/____ Result____mm

Contact/LTBI Information **TB Skin test** ☐ Not Done
TST #1 Date ____/____/____ Result _____mm TST#2 Date ____/____/____ Result_____mm
CXR ☐Not Done Date ____/____/____ ☐Normal ☐Other:_____
Last known exposure to index case ____/____/____ Place/intensity of exposure:_____

Medications ☐ this referred case/suspect ☐ this referred contact/LTBI

Drug	Dose	Start date	Stop date

Planned completion date ____/____/____
DOT ☐No ☐Yes: start date ____/____/____
☐Daily ☐1x W ☐2x W ☐3x W
Last DOT Date _____/_____/_____
Adherence problems/significant drug side effects:
_____
_____
_____
Patient given _____ days of medication

Comments_____
_____
_____

For non-Class 3/5 referrals indicate if: ☐Follow-up requested ☐No follow-up requested
NTCA 3-2002

O. Interjurisdictional TB Notification Follow-up form

Interjurisdictional TB Notification Follow-up

☐ 30-day status: ☐ located ☐ not located
☐ Interim
☐ Final

Date Notification Received ____/____/____

Return follow-up form to:

Name _____ Fax number _____

Address _____ City _____ State _____ Zip Code _____

Jurisdiction _____ Phone number _____

Patient name_____ Date of birth ____/____/____
Last First M.I.

Sex ☐ Male ☐ Female

☐ **Case:** Indicate reason therapy stopped and outcome date ____/____/____

Send F/U2 to reporting jurisdiction RVCT#_____

☐ Completed

☐ Moved to: address _____

city_____county_____state_____

Telephone ( )_____

☐ Lost (after initially located) ☐ Never located ☐ Uncooperative or refused

☐ Not TB ☐ Died ☐ Other:_____

☐ **Suspect/Source Case Finding:**

☐ Verified* by lab ☐ Verified* by clinical definition

☐ Verified* by provider diagnosis ☐ Not verified

☐ Other:_____

*If verified, and referring jurisdiction will submit the RVCT, complete **Case** outcome above

☐ **Contact (send local contact form, if follow-up performed):**

☐ No follow-up performed ☐ Never located

☐ Evaluated: ☐ Class II ☐ Class III ☐ Class IV ☐ No infection

☐ Started treatment ☐ Continuing treatment

☐ Completed treatment ☐ Other:_____

☐ **LTBI/Convertors:**

☐ No follow-up performed ☐ Never located ☐ Started treatment

☐ Continuing treatment ☐ Completed treatment ☐ Other:_____

Comments:_____

_____

_____

Person completing form_____ Date completed ____/____/____

NTCA 5-2002